K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Cost reports must be fully, clearly and accurately completed, all required attachments must be submitted and any requests for additional information or clarification must be provided before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized agent is not provided within ten (10) days of the provider's receipt of the request, payments will be withheld from the facility until the information is submitted. If information requested is not received by June 1 prior to the rate determination date, rate increases based upon the cost report will not be effective until sixty (60) days after receipt of requested information, and rate decreases based upon the cost report will be retroactive to the July 1 rate determination date.

9. The Division will not accept amended cost reports for rate determination unless they are received by March 31 prior to the rate determination date. Under no circumstances will the Division accept amended cost reports for rate re-determination after the rate has been established.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by one (1) of the following persons authorized by the governing body of the provider

to make such certification: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner, or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a licensed notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity --

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____ (provider name and number) _____ for the cost report period beginning _____ 19____ and ending _____ 19____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____

Signature Title Date

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. A provider must retain all records and documentation for seven (7) years from the cost report filing date. All current providers, regardless of length of participation in the Medicaid program, are responsible for providing access to the facility's records and documentation for seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.

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2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the Medicaid services were provided to another in-state location that is acceptable to the Division or its authorized agent. The provider must reimburse the Division or its authorized agent for reasonable travel costs necessary to perform the field audit in any out-of-state location, if the location is acceptable to the Division.

(E) Change is Provider Status.

1. Upon termination of participation in the Medicaid program or change of ownership, the provider is required to submit a cost report for the period ending with the date of termination or change, regardless of its tax period. The fully completed cost report with all required attachments and documentation is due within forty-five (45) days after the date of termination or change.

2. If a cost report is more than ten (10) days past due, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider.

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(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the Pediatric Nursing Care Facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity or entities that own, control or manage one (1) or more other facilities, records of central office and other cost incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Allocation of central office or pooled costs to individual facilities shall be consistent from year to year. If a desk review or field audit establishes that records are not maintained so as to clearly identify information required by this rule, none of the commingled cost shall be recognized as allowable cost in determining the facility's Medicaid per-diem rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

3. Certain home office or related management company costs that would otherwise be reported in the patient care component of the cost report if the facility performed the services or purchased the services independently, may be reported in the patient care cost category, if services were actually rendered at the individual facility. Allocation of these costs must be based on the hours worked on site in an individual facility. Direct patient service cost not meeting these requirements shall be reported in the general and administrative cost category.

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(11) Rate Determination.

(A) Except as provided in subsection (11)(B) below, and subject to the timely filing provisions of section (10); a facility's per-diem rate shall be determined on July 1, of each state fiscal year, beginning July 1, 1989 or the qualification date, whichever is later, based upon the data contained in the desk-reviewed and/or field audited second prior year cost report, provided the reported costs are allowable, covered, properly apportioned, properly allocated and properly classified as prescribed elsewhere in this regulation. A facility's per-diem rate shall be the sum of the patient care per-diem rate, the general and administrative per-diem rate and the capital per-diem rate. Applicable trend factors shall be applied only to the patient care component of the per-diem rate. Applicable trend factors as used in this section are the trend factors that were authorized subsequent to the last day of the facility fiscal year covered by the second prior year cost report, up to and including the trend factor adjustment which may be authorized on July 1 when the annual rate is determined. Procedures for determination of the per-diem rates in each cost category are as follows:

1. Patient Care: From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate patient care costs from lines forty-five (45) through sixty (60), and sixty-two (62) through seventy-five (75), seventy-seven (77) through eighty-five (85), eighty-seven (87) through ninety-five (95), ninety-seven (97) through one hundred and three (103), line one hundred and five (105), and lines one hundred and thirteen (113)

through one hundred and twenty (120). The accumulated patient care costs will be divided by the patient days for the reporting period identified from line eight (8), item six (6), column eight (8). The result of this procedure will be the Patient Care Per-Diem Rate.

2. General and Administrative. From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate general and administrative costs from line one hundred and nine (109), line one hundred and eleven (111), line one hundred and twelve (112), and lines one hundred and twenty-two (122) through one hundred and fifty (150). The accumulated general and administrative costs will be divided by the greater of patient days for the reporting period from line eight (8), item six (6), column eight (8) or ninety percent (90%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The General and Administrative Per-Diem Rate shall be the lesser of:

A. The results of the procedure described in paragraph (11)(A)2., or,

B. Fifteen percent (15%) times the results of the procedure described in paragraph (11)(A)1.

3. Capital.

A. For long-term care facilities which were certified for participation in the Medicaid Program at anytime prior to June 30,

1989, and with valid participation agreements in effect on June 30, 1989, and which satisfy all the qualifications necessary for participation in the Pediatric Nursing Care Program described in this regulation, the per-diem rate for capital under this regulation shall be the sum of lines one hundred and six (106), one hundred and seven (107), and one hundred and eight (108) and one hundred and ten (110) from the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, divided by the greater of patient days for the reporting period from line eight (8), item six (6), column (8) or ninety-three percent (93%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The capital cost per-diem rate shall be fixed, and will not be adjusted except as may be authorized under sections (12) or (13).

B. For new facilities the per-diem rate for capital shall be the sum of the building, building equipment and moveable equipment rate, plus the land rate, plus the working capital rate determined in accordance with the following procedures. The capital cost per-diem rate shall be fixed, and will not be adjusted except as may be authorized under sections (12) or (13).

(I) The building, building equipment and moveable equipment rate will be computed as follows:

(a) Determine the lower of --

I. Actual acquisition cost, which is the original owner's cost to construct or acquire the building including moveable equipment but excluding land costs, or

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II. Reasonable construction or acquisition cost computed by applying the Dodge Calculator as defined in subsection (4)(I) of this rule for the city, St. Louis, Kansas City or Columbia, geographically closest to the facility, multiplied by one hundred eight percent (108%) as an allowance for fees authorized as architectural or legal not included in the Dodge Calculator, multiplied by the square footage of the facility not to exceed three-hundred twenty-five (325) square feet per bed plus an allowance of one thousand five hundred dollars ($1,500) per bed for moveable equipment.

(b) Multiply by a return rate of twelve percent (12%); and

(c) Divide by ninety-three percent (93%) of the facility's total available beds times three hundred sixty-five (365) days.

(II) The land rate is computed as follows:

(a) The maximum allowable land area is defined as five (5) acres for a facility with one hundred (100) or less beds and one (1) additional acre for each additional one hundred (100) beds or fraction thereof for a facility with one hundred one (101) or more beds.

(b) Calculation.

I. For facilities with land areas at or below the maximum allowable land area, multiply the acquisition cost of the land by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds times three hundred sixty-five (365) days.

II. For facilities with land areas greater than the maximum allowable land area, divide the acquisition cost of the land by the total acres, multiply by the maximum allowable land areas, multiply by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds times three-hundred sixty-five (365) days.

III. The working capital rate will be twenty cents ($.20) per day. This amount was determined to be the average daily balance due to a facility for services provided to the state with a return rate of twelve percent (12%), divided by ninety-three percent (93%).

IV. If a provider does not provide documentation in support of actual acquisition cost necessary to determine the per-diem rate for capital, the sum of the building, building equipment and moveable equipment rate, the land rate and working capital rate will be established as a per-diem rate of six dollars ($6.00).

(B) New Facilities.